BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOHN V. DOMMISSE, M.D.,** Holder of License No. **22164** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-08A-22164-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (License Revocation)

On August 6, 2008, this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge (ALJ) Diane Mihalsky's proposed Findings of Fact and Conclusions of Law and Recommended Order. John V. Dommisse M.D., ("Respondent") appeared before the Board, special Counsel Michael W. Sillyman represented the State. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board ("the Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. The Board has issued License No. 22164 for the practice of allopathic medicine in the State of Arizona to Respondent John V. Dommisse, M.D.

3. On October 20, 2003, the Board issued a final order in case no. 03F-22164-MDX against Dr. Dommisse's license to practice allopathic medicine in the State of Arizona.[1] As a result of Dr. Dommisse's appeal to superior court, on January 17, 2006

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[1] The Board's order contained additional information on Dr. Dommisse's background and credentials, as follows:

> 3. Respondent received his formal medical training at the University of Cape Town Medical School in South Africa, graduating in 1965.
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> 4. Respondent completed a general practice residency in Bridgeport, Connecticut, in 1967, at Bridgeport General Hospital.
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> 5. Respondent obtained Canadian board certification in psychiatry in 1976, after completion of a residency-training in adult, adolescent and geriatric psychiatry at the University of Toronto's Clarke Institute of Psychiatry.
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> 6. Respondent holds medical licenses in South Africa, Ontario, Canada, Virginia, Connecticut and Arizona.
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> 7. Following his residency in Toronto, Respondent became a faculty member at the University of Toronto and headed the Toronto Western Hospital Psychiatry Day Hospital Program.
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> 8. In approximately 1978, Respondent relocated to Portsmouth, Virginia where he practiced psychiatry as the Director of Out Patient Services at the Maryview Community Mental Health Center attached to Maryview General Hospital.
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> 9. After two years, Respondent entered private practice in Portsmouth, Virginia in psychiatry.
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> 10. Respondent began practicing "nutritional and metabolic" medicine while in Virginia. He did not undertake any formal study or training in nutritional and metabolic medicine. Rather, he engaged in self-study primarily by locating and reviewing articles from various sources. His self-study on these topics took place from the mid-1970s to the present.
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> 11. Over the period of time while he was practicing in Virginia, Respondent started using nutritional and metabolic methods in reference to his psychiatric practice.

the Board issued an amended final order against Dr. Dommisse's license. In the amended order, the Board concluded that Dr. Dommisse had violated applicable statutes and rendered care that was below the standard for allopathic physicians in Arizona by diagnosing and treating patients without performing a physical examination of them; diagnosing patients with various conditions, including systemic candidiasis, hypothyroidism, macrocytosis, and diabetes, without appropriate supporting symptoms or test results; prescribing excessive thyroid hormone replacement medications, which resulted in some patients developing iatrogenic or physician-caused hyperthyroidism; altering laboratory reference ranges to interpret normal laboratory results as abnormal; and using improper Current Procedural Terminology ("CPT") coding to bill at a higher rate.

4. As a result of the Board's findings in case no. 03F-22164-MDX, the Board issued a decree of censure against Dr. Dommisse and placed his license on probation for a term of five years. Among other probationary terms, Dr. Dommisse was ordered to "practice nutritional and metabolic medicine within the standards of care for allopathic physicians in the State of Arizona" and at least twice a year to be subjected to chart review by Board staff.

5. While Dr. Dommisse was under the Board's decree of censure and during the 5-year term of probation in Case No. 03F-22164-MDX, the Board received a complaint that Dr. Dommisse improperly prescribed thyroid medication and refused to forward a

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12. Over a period of time with self-study, Respondent's nutritional and metabolic practice evolved from a purely psychiatric practice to a more general practice treating other diseases.

13. Respondent relocated his medical practice from Virginia to Tucson, Arizona in 1994.

patient's records to another treating physician. As a result, the Board initiated case no. MD-03-1046.

6. Following review by outside medical consultant ("OMC") of case no. MD-03-1046, the Board determined to conduct a review of Dr. Dommisse's patient records, which resulted in case no. MD-03-1046A. The chart review of ten patients revealed multiple concerns, including documentation issues, improper interpretation of laboratory tests, inappropriately diagnosed thyroiditis, and diagnoses and treatment of medical conditions without ever performing a physical examination.

7. The Board initiated case no. MD-05-0086A at the suggestion of its medical director, who was reviewing a separate complaint against Dr. Dommisse. The records indicated that Dr. Dommisse had treated a patient for hypothyroidism with thyroid medication for approximately two years without actually physically seeing the patient or performing a physical examination of her.

8. The Board initiated case number MD-06-0925A following a patient complaint that Dr. Dommisse had over-prescribed thyroid medication.

9. The Board initiated case number MD-06-0937A as a compliance case relating to the Decree of Censure. The Board's review of two patient charts found that Dr. Dommisse had deviated from the standard of care for allopathic physicians in the State of Arizona by making diagnoses not supported by documentation, failing to address abnormal laboratory values, and not documenting histories or physical examinations.

10. The Board initiated case number MD-07-0139A as the result of a complaint regarding Dr. Dommisse's treatment of a patient for hypothyroidism.

11. Dr. Dommisse requested a hearing on the Board's various complaints and the Board forwarded the consolidated matters to the Office of Administrative Hearings for the scheduling of an administrative hearing. The Board issued a Complaint and Notice of

Hearing, which included extensive factual allegations on the six complaints and charged Dr. Dommisse with unprofessional conduct as defined by A.R.S. § 32-1401(27)(e), (j), (q), (r), (gg), (ll), and (ss) and provided notice that it would seek to revoke his license under the factors set forth in A.A.C. R4-16-603(18)(c)(ii).

12. A hearing was held on four consecutive days, beginning on April 28, 2008. The Board presented the testimony of Vicki Johansen, a case manager for its Investigations Unit, Suzanne Grabe, who oversees its Licensing Division, Kelly Sems, M.D., its chief Medical Consultant, and OMCs Miriam Anand, M.D., Kristin Hanson, M.D., and Philip Scheerer, M.D., and had admitted into evidence 34 exhibits. Dr. Dommisse represented himself, testified on his own behalf, presented the testimony of his patient AS, Jr., offered into evidence 34 exhibits and had admitted 18 exhibits.

13. On the last day of hearing, May 1, 2008, at approximately 2:45 p.m., after the Administrative Law Judge sustained the Board's attorney's objections to some of Dr. Dommisse's exhibits, he referred to the administrative hearing as a "kangaroo court" on the record. After the Administrative Law Judge admonished Dr. Dommisse to show respect for the tribunal or leave the hearing room, Dr. Dommisse chose to leave the hearing. Although the Board's attorney did not have an opportunity to cross-examine Dr. Dommisse, he requested that the Administrative Law Judge consider Dr. Dommisse's testimony and the exhibits that were admitted into evidence, including those that were admitted over the Board's objections, in her recommendations to the Board.

EVIDENCE PRESENTED AT HEARING

Case No. MD-03-1046

Patient RSH

14. On October 16, 2003, the Board received a complaint from another physician that Dr. Dommisse improperly prescribed thyroid medication to RSH and refused to forward her records to him.

15. The Board assigned the complaint to OMC Kristin Hanson, MD to investigate. Dr. Hanson graduated with a medical degree from St. Louis University in 1991 and has completed residencies in internal medicine and a fellowship in endocrinology. At the time of the hearing, she was Senior Medical Director of Novo Pharmaceuticals, which manufactures drugs to treat diabetes.

16. At the time of the complaint, RSH was a 72-year-old female who came to Dr. Dommisse on complaints of osteoarthritis, bronchial asthma, and osteoporosis.

17. Dr. Hanson reviewed RSH's medical records. She testified that, between 1998 and 2003, Dr. Dommisse treated RSH with thyroid hormone replacement without demonstrating the presence of thyroid disease.

18. Dr. Hanson testified that, during Dr. Dommisse's treatment of RSH, he placed her on a thyroid hormone dose that led to an over-replacement of thyroid hormone with subsequent Thyroid-Stimulating Hormone ("TSH"), free Triiodothyronin ("T3") and free T4 in the hyperthyroid range.

19. Dr. Dommisse treated RSH over a five-year period without a single entry in the medical records that he had conducted a physical examination of her.

20. Over the course of Dr. Dommisse's treatment of RSH, he treated and billed her without documentation of a chief complaint, a history, a physical examination, a review of past medical history, a review of medication, a review of systems, or an assessment or plan.

21. Following a request for RSH's medical records by another physician with a signed medical release form from RSH, Dr. Dommisse contacted RSH and convinced her to withdraw her release and request and then refused to forward the medical records.

22. Dr. Hanson testified that Dr. Dommisse provided hormone replacement therapy to RSH to unacceptable levels for estrogen replacement and then failed to refer her to a gynecologist despite a number of encounters where the patient complained of symptoms and signs of estrogen excess and abnormal uterine bleeding.

23. A handwritten note in Dr. Dommisse's file for RSH indicates that, on June 29, 1998, she called to request an emergency appointment because she was very concerned, because after beginning hormone replacement, she had started having periods. She had one from June 14 to June 22, 1998 and had started again on June 28, 1998. A second note indicated that, later on June 29, 1998, RSH called again and informed Dr. Dommisse that she was about to go on a 10-day vacation and wished to have the bleeding resolved before her departure. These two notations were the only records about this matter referred to in the hearing.

24. Dr. Dommisse's "Subsequent Detailed Nutritional Metabolic Management (30')" note dated January 20, 1999, notes that RSH "had to quit the bi-estrogens for one day a week because of spotting, which took care of that problem and now she will try it again."

25. A typewritten note dated September 22, 1999 stated that RSH "had called to tell you she went to the ER yesterday for a circulation problem in both arms. The doctor said the thyroid lab report showed hyperactivity, so told her to drop the Levoxyl and that's what she did. She asked: Do you have another opinion on this situation?" Dr. Dommisse had written on the note, stating that he disagreed with the doctor because "I bet he only did a TSH."

26. RSH's file includes a note dated November 16, 2001 that, "[s]ince my HRT prescriptions were refilled (early this year) I have been spotting on almost a constant flow (never fills a Kotex pad)."

27. A note dated August 20, 2003 states that RSH was cancelling her September 2, 2003 appointment because "she has to see what else happens, as she's going to be scheduled for major surgery (hip replacement or another hip replacement)."

28. A note dated September 18, 2003 states that RSH "said you were going to give her the names of some surgeons who would work with her because of the thyroid. She was rejected a Mayo because of that."

29. RSH's file also contains a typed message from RSH dated October 14, 2003, that "she needs to speak without re: the uproar with Dr. Lending. She wants to be sure you understand what her position is – with you/against Dr. Lending."

30. Dr. Dommisse's file for RSH includes a letter "to whom it may concern," dated January 24, 2004 from RSH and her husband. The letter states that RSH went to see Robert Lending, MD, after being told by an acquaintance that he was an "excellent diagnostician." RSH and her husband went to an appointment with Dr. Lending, but were not pleased when "[u]pon hearing Dr. Dommisse's name he began aggressively questioning her thyroid treatment and began carrying on about the condition of her thyroid (which was, and is fine)." After the appointment, "Dr. Dommisse . . . questioned Dr. Lending's request and called [RSH] personally to get her permission." The letter concluded that these events had "caused a lot of distress" for RSH; she "had no idea that the visit to Dr. Lending would result in so much turmoil."

31. Dr. Hanson testified that the standard of care for the diagnosis and management of a patient who is believed to have hypothyroidism is to perform a thorough history and physical examination, including a thyroid examination, in addition to

the measurement of a high sensitivity TSH level and other related testing deemed necessary. Dr. Dommisse deviated from this standard.

32. Dr. Hanson testified that the standard of care for the treatment of a patient diagnosed with hypothyroidism, based on symptoms plus an abnormal TSH, is to place her on Levothyroxine and to adjust the dose to obtain a TSH within the normal range of 0.3 and 3.0 acceptable levels. Dr. Dommisse deviated from this standard.

33. Dr. Hanson testified that the standard of care requires a physician to refer a patient on estrogen replacement therapy who is experiencing abnormal uterine bleeding to a gynecologist for further evaluation. Dr. Dommisse deviated from this standard.

34. Dr. Hanson testified that Dr. Dommisse also deviated from the standard of care by placing RSH on supplemental estrogen leading to unacceptable levels of estrogen replacement in a post-menopausal woman. The only reason to prescribe estrogen replacement therapy would be to relieve hot flashes, vaginal dryness, and other symptoms for a patient going through menopause.

35. Dr. Hanson testified that the claimed bone density improvement that Dr. Dommisse noted in RSH's chart was "spurious." Fractured vertebra can cause bone density scans to show improvement in scores.

36. Dr. Hanson testified that Arizona statute requires allopathic physicians to provide patient records upon receipt of a signed authorization or release.[2] They are not allowed to contact the patient to ask them to reconsider the release.

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[2] A.R.S. § 32-1401(27)(rr) includes among the definitions of "unprofessional conduct" "[f]ailing to make patient medical records in the physician's possession promptly available to a physician assistant, a nurse practitioner, a person licensed pursuant to this chapter or a podiatrist, chiropractor, naturopathic physician, osteopathic physician or homeopathic physician . . . on receipt of proper authorization to do so from the patient . . . ." This statutory subsection was not charged in the Board's complaint and notice of hearing.

37. Dr. Hanson testified that Dr. Dommisse's deviations from the standard of care in his treatment of RSH resulted in the inducement of iatrogenic hyperthyroidism, as evidenced by documented weight loss, osteoporosis, and a delay in needed right hip replacement for a degenerative joint disease once it was noted in medical records that she was in a hyperthyroid state. Further, the patient could have suffered from endometrial carcinoma, deep venus thrombosis, breast cancer, or other complications due to excess estrogen.

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38. As a result of the Board's investigation of the complaint involving RSH, the Board ordered a random review of patient records pursuant to the order of probation.

39. The Board hired OMC Philip Scheerer, MD to perform the review. Dr. Scheerer graduated from Northwestern Medical School in 1958. He completed a residency in internal medicine and a fellowship in hematology. He practiced internal medicine and hematology in Phoenix until 2000, when he retired. He worked as an OMC for the Board between 2003 and 2005.

40. In January, 2005, Dr. Scheerer reviewed 10 files from Dr. Dommisse's office, which had been selected at random. The files were similar in many respects, including the following:

a. an intake sheet prior to the first appointment, consisting of the patient's main complaints, age, medical insurance, willingness to have one-third pint of blood drawn for tests, and notification that Tiburon Diagnostic Laboratory was Dr. Dommisse's laboratory of choice and that the patient could save significant expense by paying up front privately for tests;

b. a private contract for patients on Medicare, since Dr. Dommisse does not take assignment;

c. a disclaimer form since Dr. Dommisse does not do routine physical examination, only focused examination when indicated, described *infra* at Finding of Fact No. 209;

d. notes in the margin of the intake sheet and a one- to two-page report of presenting problem, medication, food and drug history, and systemic review; and

e. provisional diagnoses and recommendations with the first recommendation almost routinely being "Several vitamin, mineral, special thyroid and other blood tests to find the causes or other aggravating factors in these conditions" (this recommendation is referred to below as "the standard recommendation").

41. Dr. Dommisse then orders a large number of laboratory studies that almost routinely include CBC, chemistry panel, lipid panel, thyroid panel, including anti-TPO autoantibodies, vitamin B-12, vitamin D, vitamin E, IGF-1 (growth hormone), amino acid profile, basic food panel, numerous metals, candida antibodies, Mycoplasma antibodies, and NK function. Other studies are also frequently ordered including testosterone, estradiol, progesterone, osteocalcin, and free insulin levels.

42. Dr. Dommisse made many notations and prescriptions on the lab sheets and sometimes on the initial encounter dictation sheet.

43. Dr. Dommisse did not record a progress-follow-up note on any of the ten charts inspected.

44. Dr. Dommisse did not record a physical examination, even focused, on any of the ten charts at any point in his care of the patient.

45. Dr. Scheerer provided an overview of his review at the hearing. Dr. Dommisse's charts were exceedingly difficult to follow. The SOAP format, which stands for the patient's Subjective complaint, the physician's Objective findings, the physician's Assessment or impressions or conclusion, and a Plan of treatment, is standard for every

allopathic physician's records of every office visit. Dr. Dommisse's charts do not include any of the SOAP elements. A subsequent physician would have to spend hours analyzing Dr. Dommisse's charts to have any idea what he did to treat the patient's complaints with what outcome. The results of treatment were especially hard to ascertain, since Dr. Dommisse did not perform physical examinations. The laboratory results were in no order. Dr. Dommisse made comments on lab sheets that were hard to follow. Dr. Scheerer could not determine Dr. Dommisse's thoughts on patient care from visit to visit.

Patient JTK

46. At the time of treatment, JTK was a 32-year-old male who came to Dr. Dommisse for a thyroid check. The intake sheet was dated February 12, 2004 and the first encounter is September 10, 2004. JTK complained of anxiety, sinus congestion, and depression.

47. Dr. Dommisse made no notation of a physical examination but listed eight provision/working diagnoses, including thyroiditis, anxiety disorder, memory disturbance, insomnia without sleep apnea, dry skin, sinusitis, common migraine, immune deficiency, and major depressive disorder, recurrent episode, partial remission.

48. Dr. Scheerer testified that most of Dr. Dommisse's diagnoses of JTK were probably psychiatric rather than physical or medical.

49. In addition to the standard recommendation, Dr. Dommisse listed the following recommendations on the patient's chart: (a) Seroquel 25 mg tablet, one-fourth or one-half or one after supper daily for anxiety; (b) Guaifenesin 600 mg tablets two every 4 to 6 hours as needed; and (2) to analyze blood tests in about 2½ weeks. Dr. Dommisse listed JTK's prognosis as "[p]robably very good. The use of Seroquel in a nutritional practice is a wonderful solution to anxiety as it is not habit-forming and the

tardive dyskinesia does not occur in nutritional medical practices, and I have even reversed it in full-blown cases, so I am not concerned about that at all. Whatever we find in the blood work and correct will probably help him also, possibly even his main conditions."

50. The laboratory sections of the charge include various testing results with notations that "[s]ome of the ranges listed . . . are those established by the ordering physician and are given at his or her request." There is also a notation under NK cell function without viability that part of this test has been developed by Tiburon Diagnostic Laboratory and has not been cleared or approved by the FDA and that the FDA has determined that such clearance or approval is unnecessary.

51. Dr. Scheerer testified that he did not know the basis of Dr. Dommisse's diagnosis of JTK with immune deficiency. The NK cell test was not approved by the FDA.

52. The chart also contains encounter forms (billing sheets) dated September 24, 2004, October 21, 2004, November 4 and 9, 2004, December 6, 2004, and January 13, 2005. There are no comprehensive written or typed office visit notes for these encounters. Dr. Dommisse wrote short notes in the margin of the dictated form of September 10, 2004.

53. At the back of the chart are copies of prescriptions written by Dr. Dommisse. Some are scratched out with notations made.

54. Dr. Scheerer testified that the standard of care in the treatment of this patient for thyroid problems includes a physical examination and a written or typed office visit note for every office visit and the ordering of laboratory tests that are appropriate for the differential diagnoses. In addition, an allopathic physician must be fully knowledgeable regarding the medications he prescribes.

55. Dr. Scheerer opined that Dr. Dommisse deviated from the standard of care in the treatment of JTK by:

a. failing to perform a physical examination on the initial visit on September 10, 2004, or on five subsequent office visits through January 13, 2005;

b. failing to maintain written or typed office visit reports on any of the five office visits following the initial office visit;

c. listing eight diagnoses on the initial office visit without supporting documentation in the record for each diagnosis;

d. failing to adequately inform JTK regarding the risk and prognosis of tardive dyskinesia as a potential side effect of Seroquel.

56. Dr. Scheerer testified that Dr. Dommisse's deviations from the standard of care resulted in unnecessary medications and the increased risk of missed diagnoses, since the patient was treated for thyroid disease without the thyroid gland ever being examined by Dr. Dommisse. In addition, JTK risked increased delay in the diagnosis of drug side effects since no physical examination was done, i.e., possible tardive dyskinesia in a patient on Seroquel.

57. Dr. Scheerer testified that JTK also had to pay the costs of unnecessary laboratory tests and medications. Dr. Dommisse diagnosed JTK with thyroiditis, which is not a nutritional disease and is usually treated by a general practitioner, internist, or endocrinologist.

Patient JMG

58. At the time of treatment, JMG was a 52-year-old female with complaints of anxiety, brain swelling, chronic fatigue syndrome, chemical sensitivity, weakness, and headaches. Her chart began with a phone-intake sheet dated November 1, 2004.

59. Although there is no indication of a physical examination, the initial encounter form is dated November 9, 2004, and a two-page typed report sets forth the presenting problem, medication, food and drug history, and a systemic review following by a list of seventeen provisional/working diagnoses including: migraine, memory disturbance, multiple chemical sensitivities, chronic fatigue, anxiety, dizziness, food allergies, constipation, fibroid uterus, enuresis, insomnia, dry skin, cold intolerance, hyperlipidemia, hypoglycemia, candida overgrowth, and immune deficiency.

60. Dr. Dommisse followed his provisional/working diagnoses with the standard recommendation and the following additional recommendations: (a) obtain previous lab reports; (b) appointment in two weeks to review blood test results; and (c) Seroquel 25 mg tablet, one-quarter after supper daily.

61. There is an encounter form dated November 19, 2004, and a second office visit form dated December 3, 2004, although there is no dictated or written office visit report in the record for these dates. The December 3, 2004, encounter form lists seven diagnoses including thyroiditis and vitamin B12 deficiency.

62. There are copies of three prescriptions in the back of the chart: Seroquel 25 mg, one fourth tablet per day, #25 refillable X3; Cortef 20 mg, one-half tablet q.a.m., one forth tablet q.p.m., #75 refillable X3; and super methyl B-12, 10 mg injection X1 at Swan Clinic.

63. Dr. Scheerer testified that the standard of care for the treatment of JMG includes a physical examination and complete medical history, typed or written notes for every office visit, and appropriate clinical follow up to observe drug side effects.

64. Dr. Scheerer testified that, based on the record, Dr. Dommisse deviated from the standard of care in the treatment of JMG by:

a. failing to conduct a physical examination on the patient's initial visit or any subsequent visit as evidenced by the absence of any indication of a complete history and physical examination;

b. failing to maintain a typed or written note for every office visit in the patient's file;

c. failing to perform a physician examination to rule out early onset of possible tardive dyskenesia related to the use of Seroquel; and failing to follow up with appropriate clinical review for observation of drug side effects.

65. Dr. Scheerer testified that Dr. Dommisse's deviations from the standard of care in treatment of JMG resulted in increased risk of missed diagnoses, since no physical examination were performed of JMG. In addition, JMG risked increased delay in the diagnosis of drug side effects since no physical examination was done, i.e., failure to rule out early onset of tardive dyskenesia.

Patient TLS

66. At the time of treatment, TLS was a 40-year-od schizophrenic woman being treated with several medications, including Synthroid, according to the phone intake sheet dated November 1, 2004, based on history provided by the patient's mother.

67. A copy of a prescription dated November 2, 2004 for Celexa 40 mg, #30 with 5 refills is contained in the patient's record.

68. The patient's record shows a two-page dictated note regarding history and a list of seventeen provisional/working diagnoses, including thyroiditis, major depression, menometrorrhagia, social phobia, abnormal weight gain, gastritis, memory disturbance, chronic fatigue, hypersomnia with sleep apnea, dry skin, low sex drive, palpitation, hyperlipidemia, hypoglycemia, candida overgrowth, generalized anxiety and muscle cramps. In addition to the standard recommendation, Dr. Dommisse made the following additional recommendation for TLS: (a) continuation of Celexa 40 mg and reduction of

frequency of Geodon; (b) a note that the patient signed a Medicare private contract; and (c) instructions for the patient to return in two and a half to three weeks.

69. Under prognosis in the patient's record, Dr. Dommisse wrote "Uncertain but hopeful because she has never had a complete blood panel and we may find significant deficiencies to account for many of her symptoms, even the psychotic ones . . . ."

70. The laboratory test results for December 1, 2004 contain considerable handwritten notes in which, among other notations, show an interpretation of low iron reading of 41 as "lack of mobilizing, not deficiency" and interpretation of an elevated candida IgG as "chronic overgrowth."

71. A second encounter form is dated December 3, 2004. There is no typed or written note and no indication of a physical examination. The diagnoses include thyroiditis, as well as vitamin B-12 deficiency and systemic candidiasis. There are fifteen diagnoses on the encounter sheet.

72. Dr. Scheerer testified that systemic candidiasis is an unusual diagnosis that is not support by TLS' medical records. There are all kinds of common candidiolitis, such as oral and vaginal. Systemic candidiasis is relatively rare and usually requires hospitalization and treatment with antibiotics. Dr. Dommisse did not treat TLS for systemic candidiasis.

73. A January 24, 2005 encounter form lists twenty diagnoses. There are no typed or written notes for the encounter on January 24, 2005 or for a previous encounter on December 7, 2004 and no indication of a physical examination.

74. Dr. Scheerer opined that the standard of care in the treatment of TLS required that initial office encounters include a history and physical examination; differential diagnoses that reasonably relate to the history and physical examination data; proper interpretation of laboratory results; a physical examination of the thyroid prior to

treatment of a patient diagnosed with thyroid disease. Dr. Scheerer admitted at hearing that, for a psychiatric patient who has run out of previously prescribed psychotropic medication, the standard of care may allow an emergency prescription prior to formation of a formal doctor-patient relationship to maintain and prevent deterioration in the patient's condition.

75. Dr. Scheerer opined that Dr. Dommisse deviated from the standard of care in his treatment of TLS by:

a. not conducting a complete physical examination of the patient;

b. failure to maintain office visit notes in the chart for patient visits on December 3, 2004 and January 24, 2005;

c. misdiagnosing vitamin B-12 deficiency, misinterpreting the significance of a low iron level without further workup and misinterpreting the significance of an elevated candida IgG antibody titer; and

d. diagnosing and treating thyroiditis when there was no record on the chart of any examination of TLS' thyroid gland.

76. Dr. Scheerer opined that, by no conducting a physical examination, including a thyroid examination, Dr. Dommisse placed TLS at increased risk for misdiagnosis and treatment. By misinterpreting the significance of a low iron level without further workup and the significance of an elevated IgG antibody titer, Dr. Dommisse placed TLS at increased risk of misdiagnosis and treatment. By misdiagnosing TLS with a Vitamin B-12 deficiency when there was no supportive clinical evidence, Dr. Dommisse may have increased TLS' anxiety, which was troubling because TLS was known to be anxious even before any misdiagnosis. Dr. Scheerer admitted at hearing that, because Vitamin B-12 is water soluble, any excess due to Dr. Dommisse's injections would not have harmed TLS.

Patient DLR

77. At the time of treatment, DLR was a 66-year-old female with a long history of hyperthyroidism, which had been treated by surgery, radioactive iodine, and a second surgery, according to the phone intake sheet dated September 21, 2004.

78. The initial encounter form is dated October 15, 2004 and is accompanied by a 2½ -page dictation consisting of history and twenty eight provisional diagnoses. There is no indication of a physical examination. In addition to the standard recommendation, Dr. Dommisse recommended vitamin K-1 and appointment two and a half to three weeks.

79. A second encounter form is dated October 25, 2004. Dr. Dommisse noted three severe deficiencies—thyroid, vitamin B-12 and the amino acid arginine.

80. Dr. Scheerer testified that DLR was already on thyroid medication and had an elevated TSH. Her B-12 level was 569, which is normal. Dr. Dommisse put DLR on Armour Thyroid medication and increased her dosage to 60 mg/day.

81. An encounter form dated November 12, 2004 shows fourteen diagnoses, including vitamin B-12 deficiency and systemic candidiasis. There is no typed or written office visit note.

82. The last encounter form is dated January 11, 2005 and contains approximately twenty-five diagnoses, including systemic candidiasis and vitamin B-12 deficiency. There is no indication of a physical examination.

83. Dr. Scheerer opined that the standard of care in the treatment of DLR required a history and physical examination; a typed or written note accompanying every office visit; accurate interpretation of laboratory test results; differential diagnoses that relate reasonably to the data obtained in the history and physical examination of the patient; and examination of the thyroid gland in the treatment of a patient with thyroid disease.

84. Dr. Scheerer testified at the hearing that, although DLR's thyroid had been removed, Dr. Dommisse still should have examined it.

85. Dr. Scheerer opined that Dr. Dommisse had deviated from the standard of care in his treatment of DLR by:

a. not including a physical examination in the office visit;

b. not writing or typing office visit notes for the dates of October 25, 2004, November 13, 2004, or January 11, 2005;

c. misdiagnosing active candida infection; and,

d. treating the patient for a thyroid disorder without performing any examinations of the thyroid gland.

86. Dr. Scheerer opined that Dr. Dommisse's deviations from the standard of care in his treatment of DLR resulted in possible mistreatment for active candida infection; and possible delay in diagnosis and mistreatment of a patient with a thyroid disorder without examining the thyroid gland.

Patient DFS

87. At the time of treatment, DFS was a 69-year-old male with a history of allergies, COPD, and a brain infection, according to the phone-intake sheet date July 6, 2004.

88. The first encounter form is dated August 13, 2004. There is a two-page dictation of history and a list of nineteen provisional/working diagnoses, including post brain abscess, immune deficiency, sinusitis, post otitis media, COPD, chronic fatigue, allergic rash, candida overgrowth, food allergies, weight loss, dizziness, muscle spasms, insomnia without sleep apnea, brittle nails, hair loss, impotence, cough, benign essential tremor, and normocytic anemia. There is no indication of a physical examination in DFS' record.

89. In additional to the standard recommendation, Dr. Dommisse recommended that DFS be treated by making an appointment in three weeks.

90. In DFS' chart for August 13, 2004 are copies of laboratory results from Carondelet St. Mary's Hospital dated June 2003 and from Tiburon Diagnostic Laboratory dated August 17, 2004.

91. Dr. Dommisse wrote on the laboratory report for September 1, 2004 that DFS' "anemia is probably [due] to mycoplasma chronic infection, lo[w] testosterone, lo[w] zinc and hi[gh] candida."

92. The second encounter form for patient DFS is dated September 3, 2004, and records eleven diagnoses including systemic candidiasis and chronic mycoplasma pneumonitis. There is no written office note and no apparent physical examination.

93. Dr. Scheerer testified that Dr. Dommisse's diagnosis of mycoplasma infection as based on a single titer of DFS' blood. The infection is like tuberculosis; once a patient is exposed, evidence remains in the blood. The infection could have been old and resolved or new and active. Dr. Dommisse did not perform any test, such as a chest x-ray, to confirm his diagnosis of mycoplasma chronic pneumonitis infection. Such a test is routine.

94. Dr. Scheerer testified that patients having systemic candidiasis are usually severely ill and have been hospitalized. Dr. Dommisse did not treat DFS for systemic candidiasis.

95. An encounter form dated November 5, 2004 shows 22 diagnoses and no typewritten office note or physical examination.

96. The final encounter form is dated December 2, 2004, and lists twelve diagnoses including systemic candidiasis and mycoplasma pneumonitis. There is no written or typed office visit note and no indication of a physical examination.

97. Dr. Scheerer testified that Dr. Dommisse diagnosed DFS as suffering from systemic candidiasis based solely on antibody titers, not a blood culture. This was not appropriate. In addition, systemic candidiasis would have required hospitalization and treatment with antibiotics, which was not done.

98. Dr. Scheerer testified that Dr. Dommisse also treated DFS with hydrocortisone, which was inappropriate without a workup, repeating the blood test, and performing a TSH test. Dr. Dommisse's diagnosis of hypoadrenaline is one of the most serious things around; he should have done a further workup.

99. Dr. Scheerer opined that the standard of care in the treatment of DFS required, at a minimum, a history and physical examination; typed or written notes for every office visit; and differential diagnoses reasonably related to information obtained in the history and physical examination of the patient.

100. Dr. Scheerer opined that Dr. Dommisse deviated from the standard of care in his treatment of DFS by:

a. failing to perform a physical examination;
b. failing to have written or typed office visit notes for the dates of September 3, 2004, November 5, 2004, and December 2, 2004;
c. misinterpreting the significance of an elevated candida IgG antibody titer in his diagnosis of systemic candidiasis;
d. diagnosis of mycoplasma pneumonitis without performing a physical examination or chest x-ray based, apparently, on the basis of an elevated mycoplasma IgG antibody titer;
e. treating DFS with a low free cortisol level with hydrocortisone without further workup; and

f. prematurely or inaccurately interpreting the significance of the patient's anemia and not recommending further workup.

101. Dr. Scheerer opined that Dr. Dommisse's deviations from the standard of care placed DFS at increased risk of side effects from prescribed hydrocortisone which may not have been indicated. There was also potential delay in diagnosis of anemia and low free cortisol and possible harm to DFS based on misdiagnoses.

Patient AMcH

102. At the time of treatment, patient AMcH was a 23-year-old male with a bipolar disorder. His family provided historical data according to the phone intake form dated July 7, 2004 and the first encounter was on August 23, 2004. There is a two-page dictated report consisting of history followed by a list of thirteen provisional/working diagnoses, including bipolar-2 disorder, abnormal weight gain, memory disturbance, chronic fatigue, muscle spasms, insomnia without sleep apnea, classical migraine, dyslipidemia, vitamin B-12 deficiency, hypoglycemia, thyroiditis, acne, and hypersomnia. The diagnoses are followed by the standard recommendation and notation of an appointment in three weeks. There is no indication of a physical examination.

103. The chart contains a laboratory report from Baptist Medical Center dated July 31, 2003, with a vitamin B-12 level of 531 with a normal range of 210-705. Next to that is a notation of 600-2000.

104. An encounter form dated September 16, 2004 lists four diagnoses including thyroiditis and vitamin B-12 deficiency. There is no written or typed office visit report and no notation of a physical examination.

105. On September 23, 2004, the encounter form lists diagnoses similar to those on the September 16, 2004 encounter form. Again, there is no typed or written office visit notation and no indication of a physical examination.

106. The encounter form dated October 25, 2004 lists nine diagnoses, with no written or typed office visit and no indication of a physical examination although the diagnoses include thyroiditis and vitamin B-12 deficiency.

107. The encounter form dated November 18, 2004 includes the diagnosis of mycoplasma pneumonitis. There is no indication of a physical examination and no mention of chest x-ray results. The diagnosis appears to be based on a comment on the November 3, 2004 LabCorp report of elevated mycoplasma IgG antibody titer of 896 (0-200) but negative IGM antibody titer. A notation indicates "chr. lo-gr. Infection."

108. The January 10, 2005 encounter form lists eight diagnoses including mycoplasma pneumonitis, thyroiditis, acne, and vitamin B-12 deficiency. There is no dictated or written office visit note.

109. The back of the chart lists copies of prescriptions for Levoxyl, Cytomel and Lithobid.

110. Dr. Scheerer opined that Dr. Dommisse deviated from the standard of care in his treatment of AMcH by:

a. failing to perform a physical examination when treating for physical problems;
b. not making written or typed office visit notes for the encounters of September 16, 2004, September 23, 2004, October 25, 2004, November 18, 2004, and January 10, 2005;
c. not noting in the chart anything to suggest a diagnosis of mycoplasma pneumonitis such as supportive historical findings, an abnormality on examination or chest x-ray; and
d. misdiagnosing mycoplasma pneumonitis by misinterpreting the significance of the lab report of an antibody titer with no documented findings on physical examination or by x-ray.

111. Dr. Scheerer opined that Dr. Dommisse's deviations from the standard of care in his treatment of AMcH resulted in possible mistreatment for misdiagnosed mycoplasma pneumonitis, especially since Dr. Dommisse did not physically examine AMcH.

Patient SHJ

112. At the time of treatment, SHJ was a 75-year-old male. His intake sheet shows a history of fatigue, glaucoma, hypothyroidism, and atrial fibrillation.

113. The initial encounter form is dated August 26, 2004. There are two copies of a two-page typed report of history and systemic review. There is no indication of a physical examination although there is a list of seventeen provisional/working diagnoses on one of the typed reports, including chronic fatigue, thyroiditis, glaucoma, cardiac arrhythmia, memory disturbance, muscle spasms, osteoarthritis, insomnia without sleep apnea, dry skin, low sex drive, gastritis, irritable bowel syndrome, food allergies, cold intolerance, hypoglycemia, tinnitus and dry eyes. The diagnoses are followed by the standard recommendation and a notation for an appointment in 3-4 weeks.

114. The November 18, 2004 report has considerable writing on it including prescription directions by Dr. Dommisse.

115. The second encounter form is dated October 7, 2004. There are seven diagnoses including thyroiditis despite a negative anti-TPO antibody test on an August 26, 2004 laboratory report. There is no written or typed office visit note and no indication of a physical examination.

116. The third encounter form is dated November 11, 2004 and contains twenty diagnoses. There is no typed or written office visit note and no indication of a physical examination.

117. The fourth encounter form is dated December 9, 2004 and lists six diagnoses, including thyroiditis. There is no typed or written office visit note and no indication of a physical examination.

118. The fifth and final encounter form is dated January 21, 2005. Copies of prescriptions for Cytomel and Levoxyl are noted at the back of the patient's chart.

119. Dr. Scheerer opined that the standard of care in the treatment of SHJ required Dr. Dommisse, at a minimum, to take a complete history and perform a physical examination; to prepare typed or written office notes for each office visit; and to make differential diagnoses which reasonably relate to the data contained in SHJ's history and physical examination; to correctly interpret laboratory results; and to periodically examine SHJ's thyroid gland after diagnosing thyroiditis.

120. Dr. Scheerer opined that Dr. Dommisse deviated from the standard of care in treating SHJ by:

a. not conducting or recording a physical examination;

b. having no written or typed office visit notes for the encounters of October 7, 2004, November 11, 2004, December 9, 2004 and January 21, 2005;

c. inappropriately diagnosing thyroiditis and having no documentation to support that diagnosis such as a positive anti-TPO antibody or abnormal thyroid examination; and

d. treating for thyroid disease without ever examining the patient's thyroid gland.

121. Dr. Scheerer opined that Dr. Dommisse's deviation from the standard of care in his treatment of SHJ exposed him to increased risk of side effects from unnecessarily prescribed thyroid replacement medication.

Patient AS, Jr.

122. At the time of treatment AS, Jr. was a 50-year-old male with a history of candida cholesterol, and hypertension, as noted on the phone-intake sheet dated October 28, 1998.

123. The first encounter form is dated December 3, 1998. There is a 1½-page typed report of history and systemic review followed by a list of thirteen diagnoses, including thyroiditis, systemic candidiasis, hypercholesterolemia, essential hypertension, abnormal weight gain, hepatitis, right hypochondrium pain, chronic fatigue, insomnia without sleep apnea, low sex drive, gastritis, sinusitis, and flatulence. These are followed by the standard recommendation and a notation of a return appointment in 5-6 weeks.

124. There is an encounter form dated December 16, 1998 with a diagnosis of and treatment for thyroiditis supported by laboratory tests from Sonora Quest Laboratories LLC of a positive anti-TPO antibody, free T4, Free T3, and a high TSH.

125. An encounter from dated January 15, 1999 has a one-half page dictation with diagnoses of thyroiditis, growth hormone deficiency, testosterone deficiency and low WBC.

126. The encounter form dated February 5, 1999 shows five diagnoses including thyroiditis but no indication of a physical examination.

127. The encounter form dated February 16, 1999 has a half-page dictation of history but no indication of a physical examination. The diagnoses are immune deficiency, auto-immune thyroiditis, mineral deficiency, vitamin E deficiency, amino acid deficiency, and toenail fungus.

128. Included with the March 16, 1999 encounter form is a half-page history and a list of ten diagnoses including thyroiditis, immune deficiency, hypercholesterolemia, mineral deficiency, Vitamin E overload and hepatitis but no indication of a physical examination.

129. The April 13, 1999 encounter form shows seven diagnoses. There is no indication of a physical examination.

130. On June 8, 1999 the encounter form has a one-page dictation of history and a list of ten diagnoses but no indication of a physical examination.

131. There are 39 encounter forms between June 22, 1999 through December 9, 2004, and eight encounter forms for purchases of supplements. There are no typed or written office visit notes, no indications of physical examinations and no evidence of correlation with laboratory studies done except for brief notes written on the initial dictation of December 3, 1998. Copies of numerous prescriptions are contained in the back of the patient chart but many are scratched out or illegible.

132. Dr. Scheerer testified that the laboratory reports of AS, Jr. definitely showed elevated TSH.

133. Dr. Scheerer opined that the standard of care in the treatment of AS, Jr. required, at a minimum, a complete history and physical examination at the initial consultation; typed or written office visit reports for each office visit; laboratory results correctly interpreted; periodic examination of the patient's thyroid gland; and a medical chart constructed so that another physician could take over the patient's care in a knowledgeable manner.

134. Dr. Scheerer opined that Dr. Dommisse had departed from the standard of care in his treatment of AS, Jr. by:

a. not conducting or recording a physical examination;

b. not making written or typed office visit notes on 39 office visits from June 22, 1999 to December 9, 2004;

c. treating for thyroid disease without a documented examination of AS, Jr.'s thyroid gland in almost fifty office visits over six years; and

d. making it impossible for another physician to assume the patient's care in a knowledgeable manner based upon the patient's chart.

135. Dr. Scheerer opined that Dr. Dommisse's deviations from the standard in his care of AS, Jr. resulted in a potential delay in diagnosis of a change in the thyroiditis condition.

Patient BSS

136. At the time of treatment BSS was a 50-year-old female whose medical problems were listed on two phone intake sheets dated April 17, 2002 as tired and on hormone replacement therapy.

137. The first encounter form is dated March 7, 2003, There is a two-page typed history and a list of twenty-seven provisional/working diagnoses including chronic fatigue, menopausal syndrome, fibromyalgia, dry skin, brittle nails, hair loss, memory disturbance, acne, candida overgrowth, atypical depressive disorder, autoimmune thyroiditis, abnormal weight gain, muscle spasms, panic disorder, trichotillomania, insomnia without sleep apnea, osteoarthritis, low sex drive, constipation, chronic low BP, peripheral neuropathy, common migraine, classical migraine with aura and neurological symptoms, osteopenia, hyperlipidemia, hypoglycemia/Syndrome X, and mineral toxity. There is no indication of a physical examination.

138. Copies of previous laboratory tests dated January 11, 2003 are in the chart.

139. An encounter dated April 7, 2003 has eight diagnoses including thyroiditis, despite a negative anti-TPO titer, and a vitamin B-12 deficiency, despite a level of 1,093. There is no written or typed office note and no indication of a physical examination.

140. An encounter form dated June 25, 2003 lists eighteen diagnoses (not all are legible). There is no written or typed office visit note and no indication of physical examination although one diagnosis is peripheral neuropathy.

141. BSS' record shows encounter forms for office visits dated July 17, 2003, September 29, 2003, October 16, 2003, January 6, 2004, February 11, 2004, April 16, 2004, June 17, 2004, November 16, 2004, and December 9, 2004. There are no written or typed office visit notes or any indication of physical examinations for any of these nine office visits.

142. There is a bone density study dated February 11, 2004 interpreted as osteopenia based on a T-score of -1.9.

143. Dr. Scheerer opined that the standard of care in the treatment of BSS required, at a minimum, a complete history and physical examination; a typed or written office visit report for every office visit; accurate interpretation of laboratory results; periodic examination of the thyroid gland once treated for thyroid disease; and a medical chart constructed so another physician could take over the patient's care in a knowledgeable manner.

144. Dr. Scheerer opined that Dr. Dommisse deviated from the standard of care in the treatment of BSS by:

a. not performing a physical examination;
b. not including a written or typed note for each office visit, except for the office visit of March 2, 2003;
c. making a diagnosis of thyroiditis and treating thyroiditis without doing a physical examination, imaging study or positive anti-TPO antibody titer;
d. making a diagnosis of vitamin B-12 deficiency when the level obtained was greater than 1000;

e. diagnosing thyroiditis rather than hypothyroidism and treating BSS without any physical examination of her thyroid gland over a period of more than 20 months; and

f. making it very difficult, if not impossible, for another physician to assume BSS' care in a knowledgeable manner based on the information available in the chart.

145. Dr. Scheerer testified that Dr. Dommisse's deviations from the standard in his care of BSS may have resulted in possible mistreatment for thyroiditis and Vitamin B-12 deficiency. By not examining BSS, Dr. Dommisse exposed BSS to the risk of a potential misdiagnosis or delay in diagnosis and by treating thyroiditis, Dr. Dommisse may have added or worsened the BSS' osteopenia.

Patient EML

146. At the time of treatment, EML was a 68-year-old female with a history of fibromyalgia and hypothyroidism, according to the phone intake sheet dated September 15, 2000.

147. The first encounter form is dated November 1, 2000. There is a two page typed report consisting of history and a list of sixteen provisional/working diagnoses, including autoimmune thyroiditis, chronic fatigue, fibromyalgia, dysphagia, sinusitis, muscle spasms, dry skin, brittle nails, menopausal syndrome, constipation, cold intolerance, migraine, hoarseness, atypical depression, tachycardia, and weight loss.

148. The diagnoses are followed by the standard recommendation and: (a) a note to increase Cytomel 12.5 mcg from one daily to b.i.d.; and (b) a notation that Dr. Dommisse will analyze the thyroid tests in one to two weeks and see the patient in follow up in two months.

149. The second encounter form is dated November 10, 2000, with the number one diagnosis of thyroiditis related to a review of laboratory test results. There is no written or typed office note and no indication of a physical examination.

150. The encounter form dated January 18, 2001 lists seven diagnoses, the first being thyroiditis. There is no written or typed office note and no indication of a physical examination.

151. On March 15, 2001, there is an encounter form noting twelve diagnoses, listing thyroiditis as number one. There is no written or typed office note and no indication of physical examination.

152. The encounter form dated May 15, 2001 lists seven diagnoses with immune deficiency as number one and thyroiditis as number two. There is no written or typed office note and no indication of a physical examination.

153. There are eighteen encounter sheets from August 7, 2001 through December 3, 2004, which list variable and numerous diagnoses. There are no typed or written notes of any of these visits and no indication of any physical examination.

154. Dr. Scheerer opined that the standard of care in treatment of EML required, at a minimum, a complete history and physical examination; a typed or written office note for every office visit; correct interpretation of laboratory results; periodic physical examination of the patient's thyroid gland; and a medical chart constructed so that another physician could take over the patient's care in a knowledgeable manner.

155. Dr. Scheerer opined that Dr. Dommisse deviated from the standard in his treatment of EML by:

a. not including a physical examination;

b. not including typed or written office notes for twenty-two office visits between November 10, 2000 and December 2, 2001;

c. listing several diagnoses on November 1, 2000 that do not relate to data in the recorded history and without conducting physical examinations;

d. diagnosing immune deficiency based on a test that is not FDA approved and which, in part, was developed at Tiburon Diagnostic laboratory and without checking more routine factors such as IgG1-5 levels;

e. failing to examine EML's thyroid gland after diagnosing her with thyroid disease on any occasion in twenty-two office visits over four years; and

f. making it impossible for another physician to assume care of EML in a knowledgeable manner based on information in the chart.

156. Dr. Scheerer opined that Dr. Dommisse's deviations from the standard of care exposed EML to risk of possible mistreatment for immune deficiency and that his failure to take a complete history or to perform a physical examination, Dr. Dommisse exposed EML to risk of misdiagnosis.

157. Dr. Scheerer opined that, by failing to examine EML's thyroid gland, Dr. Dommisse placed her at increased risk for delay in diagnosis of a change in her thyroid disease.

Case No. MD-05-0086A

Patient LB

158. The Board opened an investigation into Dr. Dommisse's treatment of LB because the records reviewed in another case suggested that Dr. Dommisse treated the patient for approximately two years without ever physically seeing her or performing an evaluation.

159. At the time of treatment by Dr. Dommisse, LB was a 29-year-old female who had been diagnosed in 1996 with Chronic Fatigue Syndrome. LB's symptoms had worsened and she claimed to be homebound as a result of her condition.

160. The Board assigned LB's case to OMC Miriam Anand, MD. Dr. Anand graduated from George Washington Medical School in 1998 and completed a residency and fellowship in internal medicine. She has been in private practice as an allergist for five years.

161. LB requested that Dr. Dommisse handle her care over the phone so she would not have to travel to his office. Dr. Dommisse agreed and was to review LB's extensive records. However, LB could not afford for Dr. Dommisse to review the records for longer than 30 minutes.

162. On May 15, 2001, Dr. Dommisse dictated a letter outlining LB's history based on his telephone conversation with her and his brief review of her medical records. He later diagnosed LB with autoimmune thyroiditis, mineral toxicity, chronic fatigue, low adrenal res [*sic*] and chronic hypotension, among other diagnoses.

163. Dr. Dommisse's diagnosis of hypothyroidism was the result of blood tests he ordered on June 6, 2001, which showed LB's TSH was slightly high at 4.48 and her T3 was borderline at 2.3.

164. On June 18, 2001, Dr. Dommisse instructed LB to continue taking her thyroid hormone despite her complaints of increased fatigue and weakness and did not repeat the laboratory tests.

165. On November 1, 2005, LB's TSH level was 0.02 and, according to her medical records, Dr. Dommisse did not consider whether she had been over-replaced with thyroid medication.

166. Dr. Dommisse diagnosed LB with aluminum toxicity and performed chelation therapy without documenting informed consent.

167. Dr. Anand testified that the standard of care when a patient complains of excessive fatigue is to complete a thorough history and physical examination to check for

low thyroid function. The examination should include visual inspection and palpation of the thyroid gland for enlargement, inspection of the skin and hair and assessment of neurological reflexes. Dr. Dommisse deviated from the standard of care in failing to perform a physical examination of LB.

168. Dr. Anand testified that the standard of care when a patient complains of excessive fatigue also includes performing laboratory studies to rule out thyroid disease and to rule out other causes of fatigue such as anemia. Dr. Dommisse deviated from the standard of care in Diagnosing LB with hypothyroidism based on insufficient history, no supporting physical examination findings, and on borderline laboratory results that were not repeated.

169. Dr. Anand testified that the standard of care in providing patients with medication is to prescribe only when indicated. Dr. Dommisse deviated from this standard by continuing to treat LB with thyroid medication after she complained of symptoms and after receiving laboratory results that indicated LB was receiving too much thyroid hormone.

170. Dr. Anand testified that Dr. Dommisse's deviations from the standard of care may have resulting in LB experiencing increased weakness and fatigue from excessive thyroid replacement. His treatment of LB with excess thyroid hormone put her at risk for potentially life-threatening arrhythmias and osteoporosis.

Patient JJ

171. The Board opened an investigation into Dr. Dommisse's treatment of patient JJ following her complaint that he had over prescribed thyroid medication.

172. At the time of treatment by Dr. Dommisse, patient JJ was a 64-year-old female with a 30-year history of hypothyroidism who was taking daily thyroid replacement medication.

173. JJ's primary concerns were to avoid type 2 diabetes, a recent increase in blood pressure, cholesterol issues, weight issues, and her thyroid.

174. On November 29, 2004, Dr. Dommisse took a history review of systems and listed several diagnoses including auto immune thyroiditis. He performed no documented physical examination.

175. Dr. Dommisse ordered numerous laboratory tests and instructed the patient to take Armour Thyroid.

176. JJ's complaint was assigned for investigation to Kelly Sems, MD, who is now employed the Board's Chief Medical Consultant. Previously, she was one of the Board's staff medical consultants.

177. Dr. Sems completed 3-year residencies in internal medicine and rheumatology. She practiced rheumatology in Iowa before becoming employed by the Board.

178. Dr. Sems testified that JJ's medical chart showed encounter forms for January 18, 2005, August 1, 2005, April 21, 2006, July 19, 2006, August 4, 2006, and August 6, 2006. None of records were in the typical SOAP format. Dr. Dommisse's records were extremely hard to understand, because information on the amount of prescribed drugs, symptoms, observed effects of prescribed drugs, and changes to the treatment plan were all in different parts of the file. The only treatment note that clearly provided Dr. Dommisse's thought processes was the November 29, 2004 "Initial complex Nutritional-Metabolic Evaluation/Counseling." This form had three handwritten columns of notes dated 6-20-05, 3-13-06, and 6-14-06 that appeared to modify the "provisional/working diagnoses."

179. In September 2006, JJ's records indicate that she called Dr. Dommisse's office to report heart palpitations, anxiety, and dizziness. Dr. Sems testified that these

were symptoms of possible thyroid medication over-replacement. Such over-replacement could also affect the heart and decrease bone density.

180. The records show Dr. Dommisse advised JJ that her symptoms were due to Metformin, which JJ was taking for diabetes. Dr. Sems testified Metformin has not been shown to cause palpitations, anxiety, or dizziness. Dr. Dommisse did not consider thyroid over-replacement. As a factor in mitigation, Dr. Sems noted that Dr. Dommisse did advise JJ to stop taking thyroid replacement medication.

181. Dr. Sems testified that the standard of care requires a physician to provide adequate care to a patient with hypothyroidism on replacement medicine with routine office visits at least twice a year with an interval history and physician examination, monitoring of hypothyroidism at least once a year with laboratory tests such as TSH and appropriate adjustments of medications as needed. Dr. Dommisse did not meet this standard.

Case No. 06-0937A

182. In connection with the Board Order dated October 20, 2003 and after the Board issued its amended order on January 18, 2006, two patient charts of Dr. Dommisse were randomly reviewed. Board consultant Dr. Sems reviewed the charts and testified at hearing concerning her opinion of the adequacy of the charts and treatment reflected therein.

Patient MPJ

183. The medical records for patient MPJ included an encounter form from February 3, 2006, an appointment card for MPJ's next appointment, laboratory results and scripts which are crossed out for Levoxyl, K Phos and KCl.

184. The encounter form has several ICD-9 codes circled for the medical diagnoses including the following: enzyme deficiency, food allergies, autoimmune

thyroiditis, vitamin E deficiency, mineral deficiency, amino acid deficiency, hypophosphatemia, low potassium and immune deficiency.

185. There is no documented history or physical examination or medication list or documentation of counseling.

186. The laboratory results showed an abnormal laboratory value for TSH of 0.02 (0.30-2.50 normal). Dr. Dommisse did not address this abnormality in the patient's records.

187. Although Dr. Dommisse diagnosed the patient with thyroiditis, there was no antibody test for autoimmune thyroiditis in the laboratory work.

188. Although Dr. Dommisse diagnosed MPJ with Vitamin E deficiency, the Vitamin E levels fell within the normal range.

189. Dr. Sems testified that the standard of care requires a physician to address abnormal laboratory values such as a TSH of .02 (0.30-2.50).

190. Dr. Sems testified that the standard of care requires a physician who makes a diagnosis to substantiate the diagnosis with supporting and corresponding history, physical examination, and laboratory work.

191. Dr. Sems testified that, although it did not appear that MPJ was actually harmed by Dr. Dommisse's failure to address the abnormal TSH level, potential harm could have resulted from the effects of a persistent hyperthyroid state. Making an incorrect diagnosis potentially subjected MPJ to treatments that were not required and could have delayed proper diagnosis and treatment.

Patient PAK

192. Dr. Sems reviewed three pages of lists of "Original Provisional/Working Diagnoses" with handwritten notes/comments made by Dr. Dommisse regarding the status of the working diagnoses on different dates, a complex nutritional-metabolic

evaluation that lasted one hour, a follow up appointment card, and order verification for labs and lab test results containing various handwritten notes by Dr. Dommisse.

193. No office notes existed beyond the initial August 10, 2001 office encounter.

194. The only notes availably were written on the 3 pages of lists of "original Provisional/Working Diagnoses" that Dr. Sems testified did not make sense.

195. On the March 17, 2006, encounter form, Dr. Dommisse diagnosed PAK with Macrocytosis, but Dr. Sems testified there were no symptoms or laboratory tests in the medical record to support this diagnosis.

196. Dr. Sems testified that PAK's medical records were inadequate and did not contain sufficient information to allow a fellow practitioner to pick up the record and provide continuity of care to PAK. The records did not contain adequate histories or examinations. Although there was a list of diagnoses, there were no outlined plans and the diagnoses rarely had supporting documentation.

197. Dr. Sems testified that the standard of care requires a physician who makes a diagnosis to substantiate the diagnosis with supporting and corresponding history, physical examination, and laboratory work.

198. Dr. Sems testified that Dr. Dommisse deviated from the standard of care in the treatment of patient PAK by failing to substantiate his diagnoses with supporting and corresponding history, physical examinations, and laboratory work. His deviation potentially subjected PAK to treatments that were not required and may have delayed proper diagnosis and treatment.

199. On cross-examination, Dr. Sems did not believe that the extensive blood tests that Dr. Dommisse ordered constituted a "complete organ systems examination" that under the AMA guidelines could be billed as complete physical exam.

Patient GVJ

200. Another health care practitioner filed the complaint regarding patient GVJ. Dr. Dommisse had diagnosed and began treating GVJ for hypothyroidism.

201. Dr. Dommisse had altered reference ranges on Quest laboratory test to reach this diagnosis and relied on GVJ's T3 and T4 levels rather than TSH levels.

202. Dr. Dommisse prescribed 30 mg TID of Armour Thyroid to GVJ. After GVJ started taking the Armour Thyroid, he started experiencing increased anxiety and agitation.

203. The Board assigned case no. MD-07-0139A to OMC Randy J. Horwitz, MD, PhD to investigate. Dr. Horwitz is the Medical Director of the Program in Integrative Medicine and an Assistant Professor of Clinical Medicine at the University of Arizona College of Medicine. Neither the Board nor Dr. Dommisse presented Dr. Horwitz' testimony, although his two reports were admitted into evidence.

204. Dr. Horwitz prefaced his initial report by saying that he recognized Nutritional Medicine as a filed of study and, although he did not agree with many of the tenets and philosophies of the practice, he understood it. He therefore restricted his "comments to the pertinent features of the complaint(s) at hand."

205. With respect to the Board's charge that Dr. Dommisse had possibly committed unprofessional conduct by altering the ranges of values that the laboratory had designated as normal, Dr. Horwitz' initial report rendered the following opinion:

> In this most serious charge, I believe that the accusation was ill-stated, vague, and largely unfounded. In examining the laboratory reports in this case, it appears that Dr. Dommisse re-defined the Quest Laboratory reference range to suit his view of where the patient's value should optimally lie. This was neither a malicious nor illegal act, in that the lab results form was clearly revised by Dr. Dommisse; indeed the original lab reference range is still readable. It appears to me that Dr. Dommisse actually took the time to discuss each lab value

with the patient—and likely modified or discussed his opinion of the ranges in the presence of the patient. He has circled the patient's lab value, then noted his view of the optimal values (versus the reference range reported by Quest). Not only is it within his rights as a physician to do such, it should be encouraged. As a consultant, I am often called upon to explain the meaning of the patient's lab values, since they are not routinely discussed in detail with the patient by the PCP. It is a refreshing change to see this level of detail in discussing lab values.

I might point out that a reference range is not always equivalent to an "optimal" value for a particular lab value. In fact, the "altering" of a reference range is commonly done in Internal Medicine. . . .

206. With respect to the charge that Dr. Dommisse had possibly committed unprofessional conduct by using T3 and T4 levels, rather than the TSH level, to diagnose GVJ with hypothyroidism, Dr. Horwitz opined:

> The first issue is that the diagnosis was made using a TSH blood test done by a CLIA-certified lab, Quest Laboratories. The complainant states that the patient did not have hypothyroidism based upon this test. This comes down to an argument regarding the exact lab value constituting a high TSH. I have consulted numerous authorities, and have had differing opinions. I will quote the following from an article by Douglas Ross, MD (Dept of Endocrinology, Harvard University School of Medicine):
>
> > "Presently there is considerable controversy as to the appropriate upper limit of normal for serum TSH. Most laboratories have used values of about 4.5 to 5.0 mU/L. A monograph published by the National Academy of Clinical Biochemistry argues that the upper limit of normal of the euthyroid reference range should be reduced to 2.5 mU/L because 95 percent of rigorously screened euthyroid volunteers have serum values between 0.4 and 2.5 mU/L [Baloch, et al. Laboratory medicine practice guidelines. Laboratory support

for the diagnosis and monitoring of thyroid disease. Thyroid 2003; 13:3]. However, a population study from Germany which excluded patients with a positive family history, goiter, nodules, or positive anti-TPO antibodies found a normal reference range of 0.3 to 3/63 mU/L [Kratzsch, et al. New reference intervals for thyrotropin and thyroid hormones based on National Academy of Clinical Biochemistry criteria and regular ultrasonography of thyroid. Clin Chem 2005; 51:1480]. The use of 2.5 mU/L as the upper limit of normal for serum TSH will increase substantially the number of patients in the United States diagnosed with subclinical hypothyroidism. Presently, controversy exists as to whether patients with serum TSH values between 5 and 10 mU/L require treatment. Until there are data demonstrating an adverse biologic significance for serum TSH values between 2.5 and 5.0 mU/L, the wisdom of labeling such patients as hypothyroid is questionable."

So, although most physicians utilize the published reference range for the TSH values, since the NACB, the Academy of the American Association for Clinical Chemistry endorses this change, there is sufficient controversy in the field to warrant careful consideration before proclaiming an "inappropriate diagnosis" violation. Dr. Dommisse is aware of this controversy, as well as the NACB opinion, so his use of this range is likely a considered opinion, rather than a neglectful or inappropriate diagnosis. With a normal fT4 and fT3, this becomes a diagnosis of subclinical hypothyroidism, the treatment of which is also controversial.

. . . .

Nonetheless, the decision to treat subclinical hypothyroidism is also controversial. I am sometimes guided by the presence of antithyroid antibodies, but in this case, they were not ordered. Also, Dr. Dommisse recommends repeat lipid profile, perhaps in recognition of the elevation in lipids associated with hypothyroidism.

207. With respect to the issue of whether the 30 mg. dose of Armour Thyroid that Dr. Dommisse initially prescribed to begin treating GVJ's diagnosed hypothyroidism constituted unprofessional conduct, Dr. Horwitz opined:

> Although I personally have found the combination of T4/T3 found in Armour Thyroid provides superior replacement in terms of patient well-being and rapid equilibration of thyroid hormone levels, I favor the synthetic formulation, rather than the Armour Thyroid natural product. Many practitioners do prefer Armour, but Dr. Dommisse is **not** using the recommended 30 mg starting dose appropriately. He prescribed: 30 mg TID. Although on maintenance most patients need 90-120 mg daily, this is a high dose to start therapy, and may be problematic in someone with subclinical disease, in that there is a risk for arryhthmias if the patient becomes hyperthyroid . . . .

[Emphasis in original.] Dr. Horwitz proceeded to quote from the manufacturer's product information.

208. With respect to the issue of whether Dr. Dommisse's records for GVJ evidenced unprofessional conduct, Dr. Horwitz opined:

> I saw no evidence to support these claims. The records were rather complete, and I believe that Dr. Dommisse believes everything he has written. Many conventional physicians disagree with the manner of his practice (Nutritional Medicine), but if we restrict our focus solely to the issue of these allegations, it becomes easier to reach conclusions.

Evidence Presented in Dr. Dommisse's Defense

209. Dr. Dommisse admitted that he does not perform or document complete physical examinations of patients. Instead, since 2003 he has required patients to sign a "Type of Practice Disclaimer," in which they acknowledge his explanation that he has not been trained as an endocrinologist, he was trained in psychiatry. Because Dr. Dommisse's "practice has 'morphed' into one that contains several aspects of

endocrinology and metabolism," he informed patients that he does not perform full physical examinations. Patients were informed that they "need[ed] to obtain full physical examinations from your primary care, or other, physician, annually or as necessary, and provide [Dr. Dommisse] with reports of the same."

210. Dr. Dommisse testified that he tells patients that he relies on others to perform physical examinations. He did not show the report of any physical examination by another health care provider that was included in the patients' records that the Board obtained from him pursuant to subpoenae and that were admitted into evidence.

211. Dr. Dommisse had admitted into evidence the AMA's CPT coding guidelines that require that, for a physician to bill at code 99205 for new patient or at code 99215 for an established patient, he must perform a "general multi-system exam or complete exam of a single organ system." Among the recognized organ systems are "hematologic/lymphatic/immunologic." Dr. Dommisse argued that the extensive blood and other tests he orders suffice for a complete physical examination for billing and for standard-of-care purposes.

212. Dr. Dommisse had admitted into evidence a paper he authored entitled "Hypothyroidism: Sensitive Diagnosis and Optimal Treatment of All Types and Grades—A Comprehensive Hypothesis," www.ThyroidScience 3(2):H1-13 (2008). The article cites peer-reviewed authorities and Dr. Dommisse's own experience. The abstract of the article follows:

> The hypothesis of this paper is that hypothyroidism (in its various forms and degrees) is often undiagnosed in its grade 3 primary, secondary (pituitary), tertiary (hypothalamic) and non-thyroidal illness hypothyroidism versions; and under-treated in all versions, including its grades 1 and 2 primary hypothyroidism versions. The current standard and alternative approaches to the diagnosis and management of hypothyroidism, and their logical inconsistencies and

> inadequacies, are discussed. The biggest losers in this neglectful situation are the elderly.
>
> An extensive review is presented. Which is then coupled with logical argument and clinical experience to clarify the hypothesis. Methods employing the *free* thyroid hormone levels (FT_4 and FT_3), by the accurate direct- and tracer-dialysis methods, respectively, and a lower normal range for the thyroid stimulating hormone level are described. These help optimize the newly developed diagnostic strategies. Their superiority over the standard conventional and alternative approaches are suggested by inferential argument and by the author's personal experience of his own case of post-surgical (thyroglossal cystectomy) hypothyroidism—missed by the medical profession for 36 years—and his clinical experience with 3,500 patients over a 16-year time period.
>
> Diagnostic strategies and treatment methods are described which refute traditional objections to measuring the FT_3 serum level—at least in the case of the serum test done by the dialysis method—and to treating the varying combinations of both T_4 and either T_3 or T_4/T_3 combination hormone preparations. The objections about aggressive thyroid treatment causing or aggravating osteoporosis and cardiac arrhythmias are found (in the author's practice) to not only be overblown, but to be entirely non-existent when corrections are made for certain mineral, vitamin, amino acid, and sex- and growth-hormonal deficiencies.

213. Dr. Dommisse testified that the Board has criticized him because one or two of his patients, when he attempted to maximize their T3, experienced tachycardia or palpitations. He testified that he adjusts the dose until he gets optimal benefit.

214. Dr. Dommisse testified that RSH had called him twice about spotting. In response, he had lowered her dosage of estrogen hormone replacement. She had called a second time, before the lowered dosage had time to take effect. If altering her dosage had not resolved her symptoms within a week, he would have referred her to a gynecologist.

215. Dr. Dommisse testified that the risks of excess estrogen replacement are "ridiculous." The dangers of thyroid hormone over-replacement have been "blown all out of proportion." With his prescription of thyroid replacement and estrogen replacement hormones to RSH, her bone density had shown improvement at every scan at 2-year intervals.

216. Dr. Dommisse testified that all the substances that he prescribes are "natural" and therefore "harmless." He placed DFS in hydrocortisone, which is identical to the naturally occurring substance. Hydrocortisone cannot be patented because it is identical to the substance that occurs naturally in the body. In contrast, internists prescribe prednisone, which increases drug companies' profits and may cause harm because it is not natural.

217. With respect to AMcH, Dr. Dommisse testified that his IgG titer was more than twice the normal level. His diagnosis of mycoplasma pneumonitis was of a condition that might, if left untreated, progress to "walking pneumonia." The condition definitely contributed to AMcH's complaints of chronic fatigue.

218. With respect to JJ, Dr. Dommisse testified that he did order her to lower her dosage of Amour Thyroid. Instead, however, she chose to go to another physician. There are other causes of tachycardia. He attempts to maximize thyroid function in his patients.

219. Dr. Dommisse testified that none of the tests that he orders is completely routine. He picks tests that are suited to the specific patient and reported symptoms. He usually orders a thyroid screen and tests to measure Vitamin B-12, Vitamin E, and Vitamin D. He orders a growth hormone test in elderly, frail, or middle-aged patients who request anti-aging treatments. He orders amino acid profiles for patients with symptoms of depression or another psychiatric condition. He orders basic food allergy tests for

patients with irritable bowel syndrome or symptoms of food allergies. He orders metal toxicity screening for aluminum and mercury in most cases. He only orders testing for copper toxicity for patients who complain of memory loss.

220. Dr. Dommisse testified that he only orders tests for candida for patients who complain of symptoms. Nutritional physicians use an elevated IgG antibody tier to diagnose systemic candidiasis that has not yet become symptomatic to the point of requiring hospitalization. He has definitely seen improvement of symptoms in such patients.

221. With respect to TLS, Dr. Dommisse testified that low thyroid can also cause heart palpitation.

222. Dr. Dommisse testified that it would be far more harmful to TLS to overlook a B-12 deficiency than to diagnose a condition that she might not have. Taking a lozenge for the rest of her life should reduce her anxiety.

223. Dr. Dommisse testified that he does not order the NK cell test routinely but only for patients he suspects of having immune deficiency disorder.

224. Dr. Dommisse testified that, since the 2003 hearing, he has increased focused examinations of patients, especially for blood pressure and pulse. If his records are still deficient, there had been no harm to patients. In any event, extensive blood tests will be more definitive in providing diagnoses than a physical examination.

225. With respect to patient JTK, Dr. Dommisse testified that nutritional physicians' patients do not get tardive dyskinesia. Although other kinds of doctors may not prescribe Seroquel for anxiety, it is not a risk for patients of nutritional physicians. He does not need to perform physical examinations of patients prescribed Seroquel, because there is no way to miss the symptoms of tardive dyskinesia. The patient begins "writhing around."

226. Dr. Dommisse offered into evidence 21 letters from physicians in support of him, which generally attest to the success of patients that they refer to him rather than specific practices. Dr. Dommisse also offered into evidence letters from 119 patients about their success under his treatment. The Administrative Law Judge sustained the Board's attorney's objections to admission based on hearsay and relevancy. Copies of these documents were provided to the Board's attorney and are included in the record but will not be considered further in this recommended decision.

227. Dr. Dommisse admitted that the better practice is to palpate the thyroid gland of patients whom he is treating for a thyroid disorder. But, since none of the patients had been harmed or had complained about his treatment, it was none of the Board's business.

228. Dr. Dommisse testified that an examination of the thyroid gland of a patient with thyroid disorder would only show enlargement or nodules. There is no way to write a report of such an examination.

229. Dr. Dommisse testified that the normal range for Vitamin B-12 in the U.S. is between 243 and 896. In Japan, the range considered to be normal is double what it is in the U.S. Japan has no incidence of Alzheimer's disease.

230. Dr. Dommisse argued that neither Dr. Sems, Dr. Anand, Dr. Hanson, nor Dr. Scheerer were his peers because they did not practice nutritional medicine. Only Dr. Horwitz was his peer, and Dr. Horwitz found no fault with his record-keeping and diagnostic practices.

231. Dr. Dommisse testified that the Board recognizes nutritional medicine as an area of specialty. It listed Nutrition as an area of interest on the 2004 and 2006 license renewal forms.

232. Dr. Dommisse testified that Nutritional physicians do not follow the SOAP format in their record-keeping. Other nutritional or complementary physicians, such as Dr. Horwitz, could understand his charts.

233. Dr. Dommisse testified that his patients had told him that they did not want to pay for the additional expense of having him prepare office notes in the SOAP format for each office visit. They preferred to have him spend his time focusing on treatment and care.

234. Dr. Dommisse testified that Nutritional physicians may not perform physical examinations, but instead rely on others to perform such examinations of their patients.

235. Dr. Dommisse testified that psychiatrists cannot perform detailed physical examinations. They examine patients by observing them during conversations. He performed his last physical examination approximately 41 years ago.

236. Dr. Dommisse testified that he practiced telemedicine and regularly treated patients from other states. He could not refuse to treat LB after her mother requested. He has experienced a 65% success rate in treating chronic fatigue patients. Conventional medicine had only a 2-6% success rate. Dr. Dommisse did not define his definition of "success" in treating chronic fatigue patients.

237. Dr. Dommisse testified that conventional medicine has a poor record in treating chronically ill patients.

238. Dr. Dommisse had testified that much of his practice focuses on treating conditions that conventional medicine has missed. Hypothyroidism is underdiagnosed in the U.S. primarily due to the sole reliance on TSH levels to diagnose it. Even if TSH levels are within normal range, more sensitive T3 or even T4 levels may show secondary, tertiary, or subclinical hypothyroidism.

239. Dr. Dommisse testified that Dr. Hanson "preferred to see his contact with RSH in a negative light." He only questioned RSH about the release because he knew that she had broken off relations with Dr. Lending, who he called a "quackbuster." RSH had confirmed that she did not want her records sent.

240. Dr. Dommisse's patient AS, Jr. traveled to Phoenix from Tucson to testify on his behalf. He was one of the 10 patients whose file Dr. Scheerer reviewed in the random audit.

241. AS, Jr. has been Dr. Dommisse's patient for approximately 10 years. When he started being seen by Dr. Dommisse, he was not required to sign a disclaimer. However, Dr. Dommisse had told him that he should have his own doctor to perform physicals.

242. AS, Jr. testified that Dr. Dommisse had palpated his thyroid after raising his dosage of Cytomel to raise his T3 level. Although AS, Jr. had experienced rapid heartbeat for a while, it resolved. Dr. Dommisse has never performed a physical examination of him.

243. AS, Jr. testified that he initially went to Dr. Dommisse because his regular doctor was not making him feel better. Every fall, he would get sick and he would stay sick with a cold all winter. He had asked his internist about his thyroid, and the internist gave him medicine, but it did not help.

244. AS, Jr. testified that Dr. Dommisse had discovered that he had Hashimoto's disease, which the internist had not found. Dr. Dommisse had put him on thyroid medication and amino acid. AS, Jr. testified he no longer gets sick. He no longer gets colds and flu. His cholesterol level has gone from 240 to 140-150, without medication. He feels better than he has in 10 years.

245. AS, Jr. also testified that his wife is also in treatment with Dr. Dommisse. She no longer gets sick.

246. AS, Jr. testified that he sees other doctors for physical examinations. He has a different primary care practitioner ("PCP") since he started going to Dr. Dommisse. Dr. Dommisse has a good relationship with his PCP.

The Board's Rebuttal

247. Ms. Grabe testified that the Board oversees medical specialties. There are 24 boards that certify different areas of specialty. There are many other subspecialties or areas of interest. The Board provides a list of subspecialties or areas of interest that the physician may choose for his entry at the Board's website, including nutritional medicine, hospitalist, and pharmaceutical medicine.

248. These areas of interest are not considered specialties and have no residencies or fellowships to prepare physicians for practice in them.

249. The Board also presented Dr. Sems' testimony and the 1997 Documentation Guidelines for Evaluation and Management Services, which is published by the AMA and provides expanded explanation of CPT codes. A comprehensive examination "should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in a box which is shaded and at least one element in a box which is unshaded." The requirements of a Hematologic/Lymphatic/Immunologic examination include physical examination of fourteen body areas, including constitutional (including measurement of any three of seven enumerated vital signs and notes concerning the general appearance of the patient) and lymphatic (which requires "[p]alpitation of lymph nodes in neck, axillae, groin, and/or other location").

250. Dr. Sems testified that Dr. Dommisse's argument that having extensive laboratory tests done sufficed for a physical examination of the patient was false, even from a billing standpoint.

APPLICABLE LAW

1. A.R.S. § 32-1451(M) provides in relevant part:

> Any doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct . . . is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance. The board may charge the costs of formal hearings to the licensee who it finds in violation of this chapter.

2. A.R.S. § 32-1401(27) defines "unprofessional conduct" to include:

> (e) Failing or refusing to maintain adequate records on a patient.
>
> . . . .
>
> (j) Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes.
>
> . . . .
>
> (q) Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
>
> (r) Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.
>
> . . . .
>
> (gg) Using chelation therapy in the treatment of arteriosclerosis or as any other form of therapy, with the exception of heavy metal poisoning without:

(i) Adequate informed patient consent.

(ii) Conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a medical peer review committee.

(iii) Approval by the federal food and drug administration or its successor agency.

. . . .

(ll) Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of the patient.

. . . .

(ss) Prescribing, dispensing or furnishing a prescription medication . . . to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . . ."

3. A.A.C. R4-16-603(18)(c)(ii) provides in relevant part as follows:

"Departures from the Standard of Care" includes those actions or omissions that violate A.R.S. § 32-1401(27)(l), (q), or (ll).

. . . .

c. Departures Caused by Cognitive Issues Involving the Physician:

. . . .

ii. Repetitive or egregious offenses may result in a Letter of Reprimand or a Decree of Censure with Probation. Offenses that are not, or are unlikely to be remediated, may result in Suspension or Revocation.

4. A.A.C. R4-16-604 includes among the aggravating factors considered in disciplinary actions the following:

6. Refusal to acknowledge the wrongful nature of the conduct.

CONCLUSIONS OF LAW

1. This matter lies within the Board's jurisdiction.[3]

2. The Board bears the burden of proof and must establish cause to discipline Dr. Dommisse's license to practice allopathic medicine under applicable statute by a preponderance of the evidence.[4] "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[5] A preponderance of the evidence is "[t]he greater weight of the evidence, not necessarily established by the greater number of witnesses testifying to a fact but by evidence that has the most convincing force; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other."[6]

3. To the extent that the Board charged Dr. Dommisse with unprofessional conduct after he redefined laboratory reference ranges and diagnosed patients with hypothyroidism or vitamin B-12 deficiencies based on those altered ranges, Dr. Horwitz' report and Dr. Dommisse's authorities establish a good-faith controversy within the allopathic medical community regarding optimal ranges for specific patients. Similarly, to the extent that the

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[3] *See* A.R.S. § 32-1401et seq.

[4] *See* A.R.S. § 41-1092.07(G)(1); A.A.C. R2-19-119; *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372, 249 P.2d 837 (1952). The Administrative Law Judge denied Dr. Dommisse's motion that the standard of proof should be "clear and convincing" based on authority from the State of Washington in an order dated April 23, 2008, which was mailed to the parties on April 25, 2008. Because the Board is also a member of the executive branch, which cannot overrule controlling judicial authority, duly enacted legislative statutes, or duly promulgated administrative regulations, she does not repeat that portion of her order. She notes for the purposes of any appeal that Dr. Dommisse eventually may take, however, that he preserved this constitutional argument by raising it in this administrative proceeding.

[5] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

[6] BLACK'S LAW DICTIONARY at page 1220 (8th ed. 1999).

Board charged Dr. Dommisse with unprofessional conduct after he diagnosed hypothyroidism based on T3 and T4 levels, rather than solely on the TSH level, Dr. Horwitz' report and Dr. Dommisse's authorities establish a good-faith controversy within the allopathic medical community regarding the appropriate diagnostic test for hypothyroidism. Because these controversies must be resolved by consensus within the allopathic medical community, the Administrative Law Judge makes no recommendation to the Board regarding Dr. Dommisse's practices in these respects in this decision, other than to recommend that such practices do not constitute unprofessional conduct in every case.

4. Dr. Dommisse's failure to perform a physical examination or to ensure that another appropriately trained professional performed a physical examination of any of his patients at any point in his treatment of them is far more concerning. Dr. Dommisse's "Type of Practice Disclaimer" cannot vitiate his failure. Patients of an allopathic physician are entitled to care within the applicable standard and cannot assume the risk of his unprofessional conduct.

5. Moreover, Dr. Dommisse did not merely give his patients nutritional supplements or dietary counseling; he gave them substances that were available only by prescription by an appropriately licensed health care provider. Dr. Dommisse admitted that he attempted to "optimize" "natural" hormones by prescribing such replacement hormones to reach higher levels than were considered safe by most allopathic practitioners. His failure to monitor the effect of such prescription by performing a physical examination or even to perform any blood tests after the initial battery placed his patients at risk and constituted unprofessional conduct. The Board's decree of censure in case no 03F-22164-MDX required such examinations.

6. Therefore, the Board has established that Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) in his care of patients

RSH, JTK, JMG, TLS, DLR, DFS, AMcH, SHJ, AS, Jr., BSS, EML, JJ, MPJ, and PAK by not performing any physical examinations on them; as defined in A.R.S. § 32-1401(27)(r) in his care of patients MPJ and PAK by violating a formal order, probation, consent agreement or stipulation issued or entered into by the Board or its executive director by failing to perform physical examinations on them; and as defined by A.R.S. § 32-1401(27)(ss) in his care of patient LB by prescribing, dispensing or furnishing a prescription medication or a prescription-only device without first conduction a physical examination or previously establishing a doctor-patient relationship.

7. Dr. Dommisse prescribed estrogen hormone replacement to RSH, who was 72 years old, post-menopausal, and had no recorded complaints to justify the prescription. Even when RSH complained of vaginal bleeding, he refused to reconsider his prescription of hormone and reduced the amount but continued the prescription, without referring her to a gynecologist. His testimony that he would have referred her to a gynecologist if her symptoms had not resolved is belied by his own records: he continued to prescribe hormone replacement and she continued to complain of vaginal bleeding. The Board has established that Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(ll) in his care of RSH.

8. The Board also established that Dr. Dommisse's excessive prescription of Armour Thyroid to patients RSH, LF, JJ, and GVJ caused over-replacement of thyroid hormone, causing actual or potential tachycardia, osteoporosis, weight loss, and other symptoms. The Board's decree of censure and order of probation in case no. 03F-22164-MDS addressed Dr. Dommisse's history of causing iatrogenic hyperthyroidism in his patients. The Board therefore has established that Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(j) in his treatment of LB; and, as defined by A.R.S. § 32-1401(27)(q) in his treatment of patients RSH, JJ and GVJ.

9. Drs. Sems, Hanson, Anand, and Scheerer all testified that they could not easily understand Dr. Dommisse's records. The Administrative Law Judge has studied Dr. Dommisse's patient records and finds that they support Drs. Sems', Hanson's, Anand's and Scheerer's opinions. The Board should reject Dr. Dommisse's argument that an allopathic physician must agree with his methods to understand his records; such an argument would preclude the flow of information and principled resolution of controversies within the profession.

10. RSH's case shows that, when a patient of Dr. Dommisse decides for whatever reason to seek a second opinion, if the subsequent physician does not understand or agree with Dr. Dommisse's care of the patient, his practice is to bully the patient. Instead of defending or explaining his care, Dr. Dommisse requires the patient to return to unquestioned acceptance to the tenets of his care, even if she continued to have worrisome symptoms, such as vaginal bleeding.

11. As RSH's case illustrates, a subsequent provider's inability to understand Dr. Dommisse's records undermines the continuity of care and could harm the patient. Dr. Horwitz' opinion to the contrary notwithstanding, the Board therefore has established that Dr. Dommisse violated A.R.S. § 32-1401(27)(e) in his records of his treatment of patients RSH, JTK, JMG, TLS, DLR, DFS, AMcH, SHJ, AS, Jr., BSS, EML, **LB**, JJ, MPJ, and PAK, and that he violated A.R.S. § 23-1401(27)(q) in his records of treatment of patients RSH, JTK, JMG, TLS, DLR, DFS, AMcH, SJH AS Jr., BSS, EML, JJ, MPJ, PAK, and GVJ.

12. The Board has established that Dr. Dommisse prescribed Seroquel to patients JTK and JMG without adequately explaining the risk of tardive dyskenesia. Dr. Dommisse's breezy explanation that "patients of nutritional physicians do not develop tardive dyskenesia" is not credible. The Board therefore has established that Dr.

Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) by prescribing Seroquel to patients JTK and JMG without adequately explaining the risk of tardive dyskenesia.

13. Dr. Dommisse diagnosed patients TLS and DFS with systemic candidiasis, DFS with hypoadrenaline, and DFS and AMcH with mycoplasma pneumonitis. The Board established that none of these patients' reported symptoms or laboratory results supported such diagnoses as they are understood by allopathic physicians. Dr. Dommisse's only defense, that nutritional physicians have their own definition of these established medical terms that does not comport with the definition of any other allopathic physician, is not established by this record. Dr. Dommisse's misdiagnoses may have caused these patients to take medication that they did not need or delayed accurate diagnoses of the cause of their reported symptoms. The Board has therefore established that Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) in his diagnoses of patients TLD, DFS, and AMcH.

14. Finally, the Board has established that Dr. Dommisse performed chelation therapy of patient LB without her informed consent. The Board therefore established that Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(gg).

15. With respect to the appropriate penalty, the consolidated charges in these matters, the Board's experts' reports and testimony, and Dr. Dommisse's testimony and conduct at the hearing leaves no doubt that the sole effect of the Board's decree of censure and order of probation in case no. 03A-22164-MDX was to make Dr. Dommisse more defiant and more committed to continuing the practices that have previously been determined to be unprofessional conduct. Although Dr. Dommisse may have contributions to make to the allopathic medical profession, under A.A.C. R4-16-

603(18)(c)(ii) and A.A.C. R4-16-604(6), he has repeatedly demonstrated that he cannot be regulated.

ORDER

Based on the foregoing, it is recommended that the Arizona Medical Board revoke License No. 22164 for the practice as an allopathic physician in the State of Arizona previously issued to Respondent John V. Dommisse, M.D. Pursuant to A.R.S. §32-1451(M) and A.R.S. § 41-1007, Respondent shall pay costs of the administrative hearing, not to exceed $20,000.00 (twenty thousand dollars).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 8th day of August, 2008.

THE ARIZONA MEDICAL BOARD

By _____
LISA WYNN
Executive Director

///

ORIGINAL of the foregoing filed this 14th day of August, 2008 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 14th day of August, 2008, to:

John V. Dommisse, M.D.
Address of Record

#246008